

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

18809
State File No. 5041

FILED JUN 14 1957

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G. Phillips Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>2219 1/2 249 North Jefferson Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>JAMES</u>		a. (First) _____		b. (Middle) _____		c. (Last) <u>HOBSON</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>May 22 1892.</u>	
9. AGE (In years last birthday) <u>65</u>		10. MONTHS <u>0</u>		11. DAYS <u>4</u>		12. IF UNDER 14 Hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Rail Road</u>			
11. BIRTHPLACE (City and State or Foreign Country) <u>Miss *</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13a. FATHER'S NAME <u>Newell Hobson</u>				13b. MOTHER'S MAIDEN NAME <u>Lizzie Parker</u>			
14. NAME OF HUSBAND OR WIFE _____				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>702-14-6915</u>				17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mallisa Richardson 2431 Dickson St. Apt. 609</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				19. MEDICAL CERTIFICATION a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Gun shot wound of the Great Vessel of the neck, suffered when shot with shot gun in hands of K. C. Wall (Cal) in room of home at 2219 1/2 North Jefferson Ave. about 23 P.M. May 26 - 1957</u> b. ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) making the underlying cause last.</u> c. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>Homicide</u>			
19a. DATE OF OPERATION _____				19b. MAJOR FINDINGS OF OPERATION <u>E-981x</u>			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>			
21a. ACCIDENT, SUICIDE, HOMICIDE (Specify) <u>HOMICIDE</u>				21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St. Louis</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
21f. HOW DID INJURY OCCUR? <u>See above</u>				22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.			
23. SIGNATURE <u>Dr. J. Earl Smith</u>				23a. ADDRESS <u>31300 Clark</u>			
23b. DATE <u>5-31-57</u>				23c. DATE SIGNED <u>5/27/57</u>			
24. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				24a. DATE <u>5-31-57</u>			
24b. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>				24c. LOCATION (City, town, or county) (State) <u>St. Louis, Co. Mo</u>			
25. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Randle & Son 3133 Bell Ave</u>				25. ADDRESS <u>J. H. Randle & Son 3133 Bell Ave</u>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....

Signature of Student Embalmer

Signed.....

Escher K. Harris

Licensed Embalmer No. *4459*

P. O. Address *41817 Ash*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.